AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ADMINISTRATORS FOR EMPLOYEE BENEFITS PLANS

Mailing Address: P.O. Box 1894 • Tacoma, WA 98401
Physical Address: 1101 Pacific Ave. Suite 300, Tacoma, WA 98402

Phone: 253.564.5611 ext. 210 • **Fax:** 253.564.5881 • **Toll Free:** 800.426.9786 ext. 210

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE.

I, the undersigned, herby authorize ______________________________ (name of healthcare plan) and any of its business associates and their respective agents and subcontractors, to disclose confidential health information about the member/insured below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY
You must complete both sides of the form. Please type or print.

MEMBER/INSURED INFORMATION

Last Name:	First Name:	M.I.:
Birth Date:	Social Security #:	

I authorize the individual(s) or company(ies) indicated below to receive protected health information regarding the member/insured named above.

Individual/company authorized to receive protected health information:		
Daytime Phone #:	Fax #:	
Address:		
City:	State:	Zip:

Individual/company authorized to receive protected health information:		
Daytime Phone #:	Fax #:	
Address:		
City:	State:	Zip:

Individual/company authorized to receive protected health information:		
Daytime Phone #:	Fax #:	
Address:		
City:	State:	Zip:

PURPOSES FOR THE RELEASE OR DISCLOSURE OF INFORMATION

☐ Disclosures are made at the request of the member/insured.

☐ Other *(Please specify)*

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DESCRIPTION OF THE INFORMATION TO BE RELEASED OR DISCLOSED (CHECK ALL THAT APPLY):

- ☐ Enrollment Information
- ☐ Claims Records
- ☐ Claims Status
- ☐ Other *(Specifically describe the records to be released below)*

EXPIRATION

- ☐ For a period of ______ month(s) from the date of my signature below: or
- ☐ Until the completion of *(Specific event or purpose of the release)*

IMPORTANT:
YOUR SIGNATURE BELOW MEANS THAT YOU UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand that the information provided under this authorization may include Protected Health Information which could contain diagnosis and treatment information including information pertaining to chronic and/or communicable diseases including but not limited to: alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted diseases; genetic disorders; and/or Sickle Cell.

I understand that the information to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance.

I understand that I may be charged a reasonable fee (only as allowed by law) for copying and mailing the disclosures to the individual(s) or company(ies) that I have designated in Section 2 above.

I understand that my ability to enroll in my healthcare plan, eligibility for benefits and payment for services will not be affected if I do not sign this form. However, I understand that without this completed form with my signature, my request to release the information described above to a third party will not be honored.

I understand that this Authorization is effective until the date or the event indicated in Section 5 above, unless I revoke this Authorization before it expires. I understand that I may revoke this Authorization at any time during its effective period by requesting such in writing to: TPSC Benefits, Attn. Privacy Officer, P.O. Box 1894, Tacoma, WA 98401-1894.

A PHOTOCOPY OF THE AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS THE ORIGINAL.

______________________________	______________
Signature of Patient/Guardian/Personal Representative	Date

____

Legal Relationship to Patient

(Must be completed if signed by guardian or personal representative)